

Update on Lyme disease: Is it bug-check season in your area of the United States?



The classic bullseye rash of Lyme

Our infectious disease colleagues warn us that this year, winter in the Northeast United States was not cold enough for long enough to kill off as many ticks as usual. Thus, we folks in Pennsylvania are in for a more burdensome Lyme disease season. We've already had children come to our office this spring with concerns of tick bites, so here's an update on Lyme disease:

Lyme disease is spread to people by blacklegged ticks. Take heart- even in areas where a high percentage of blacklegged ticks carry the bacteria that causes Lyme disease, the risk of getting Lyme from any one infected tick is low. Ninety-nine percent of the little critters DON'T carry Lyme disease... but there are an awful lot of ticks out there. Blacklegged ticks are tiny and easy to miss on ourselves and our kids. In the spring, the ticks are in a baby stage (nymph) and can be as small as a poppy seed or sesame seed. In order to spread disease, the tick has to be attached and feeding on human blood for more than 36 hours, and engorged.

In areas in the United States where Lyme disease is prevalent (New England and Mid-Atlantic states, upper Midwest states such as Minnesota and Wisconsin, and California), parents should be vigilant about searching their children's bodies daily for ticks and for the rash of early Lyme disease. Tick bites, and therefore the rash as well, especially like to show up on the head, in belt lines, groins, and armpits, but can occur anywhere. When my kids were young, I showered them daily in summer time not just to wash off pool water, sunscreen, and dirt, but also for the opportunity to check them for ticks and rashes. Now that they are older I call through the bathroom door periodically when they shower: "Remember to check for ticks!" Read our post on how to remove ticks from your kids.

"I thought that Lyme is spread by deer ticks and deer are all over my yard." Nope, it's not just Bambi that the ticks love. Actually, there are two main types of blacklegged ticks, *Ixodes Scapularis* and *Ixodes Pacificus*, which both carry Lyme and feed not only on deer, but on small animals such as mice. (Fun fact: *Ixodes Scapularis* is known as a deer tick or a bear tick.)

Most kids get the classic rash of Lyme disease at the site of a tick bite. The rash most commonly occurs by 1-2 weeks after the tick bite and is round, flat, and red or pink. It can have some central clearing. The rash typically does not itch or

hurt. **The key is that the rash expands to more than 5 cm**, and can become quite large as seen in the above photo. This finding is helpful because if you think you are seeing a rash of Lyme disease on your child, you can safely wait a few days before bringing your child to the pediatrician because the rash will continue to grow. The Lyme disease rash does not come and then fade in the same day, and the small (a few millimeters) red bump that forms at the tick site within a day of removing a tick is not the Lyme disease rash. Knowing that a rash has been enlarging over a few days helps us diagnose the disease. Some kids have fever, headache, or muscle aches at the same time that the rash appears.

If your child has primary Lyme disease (enlarging red round rash), the diagnosis is made by a doctor examining your child. Your child does not need blood work because it takes several weeks for a person's body to make antibodies to the disease, and blood work tests for antibodies against Lyme disease, not actual disease germs. In other words, the test can be negative (normal) when a child does in fact have early Lyme disease.

The second phase of Lyme disease occurs if it is not treated in the primary phase. It occurs about one month from the time of tick bite. Children develop a rash that looks like the primary rash but appears in multiple body sites all at once, not just at the site of the tick bite. Each circular lesion of rash looks like the primary rash but typically is smaller. Additional symptoms include fever, body aches, headaches, and fatigue without other viral symptoms such as sore throat, runny nose, and cough. Some kids get the fever but no rash. Some kids get one-sided facial weakness. This stage is called Early Disseminated disease and is treated similarly to the way that Early Lyme disease is treated- with a few weeks of antibiotics.

The treatment of early Lyme disease is straightforward. The child takes 2-3 weeks of an antibiotic that is known to treat Lyme disease effectively such as amoxicillin or doxycycline.

Your pediatrician needs to see the rash to make the diagnosis. This treatment prevents later complications of the disease. While the disease can progress if no treatment is undertaken, fortunately children do not get "chronic Lyme disease." Once treatment is started, the rash fades over several days. Sometimes at the beginning of treatment the child experiences chills, aches, or fever for a day or two. This reaction is normal but you should contact your child's doctor if it persists for longer.

Later stages of Lyme disease may be treated with the same oral antibiotic as for early Lyme but for 3-4 weeks instead of 2-3 weeks. The most common symptom of late stage Lyme disease is arthritis (red, swollen, mildly painful joint) of a large joint such as a knee, hip, or shoulder. Some kids just develop joint swelling without pain and the arthritis can come and go.

For some manifestations, IV antibiotics are used. The longest course of treatment is 4 weeks for any stage. Children do not develop "chronic Lyme" disease. If symptoms persist despite adequate treatment, sometimes one more course of antibiotics is prescribed, but if symptoms continue, the diagnosis should be questioned. No advantage is shown by longer treatments. Some adults have lingering symptoms of fatigue and aches years after treatment for Lyme disease. While the cause of the symptoms is not understood, we do know that prolonged courses of antibiotics do not affect symptoms.

For kids eight years old or older, if a blacklegged tick has been attached for well over 36 hours and is clearly engorged, and if you live in an area of high rates of Lyme disease-carrying ticks, your pediatrician may in some instances choose to prescribe a one time dose of the antibiotic doxycycline to prevent Lyme disease. The study that this strategy was based on and a few other criteria that are considered in this situation are described here.* Your pediatrician can discuss the pros and cons of this treatment.

Bug checks and insect repellent. Protect kids with DEET containing insect repellents. The Centers for Disease Control recommends 10 to 30 percent DEET- higher percent stays on longer. Spray on clothing and exposed areas and do not apply to babies under two months of age. Grab your kids and perform daily bug checks- in particular look in crevices where ticks like to hide such as the groin, armpits, between the toes and check the hair. Be suspicious of random scabs. Dr. Lai once had a elementary school patient who had a blacklegged tick in the middle of his forehead. The mother noticed it at breakfast, tried to brush it off, thought it was a scab and sent the boy to school. Later that day the teacher called saying, "I think your son has a bug on his face."

Misinformation about this disease abounds, and self proclaimed "Lyme disease experts" play into people's fears. While pediatricians who practice in Lyme disease endemic areas are usually well versed in Lyme disease, if you feel that you need another opinion about your child's Lyme disease, the "expert" that you could consult would be a pediatric infectious disease specialist.

For a more detailed discussion of Lyme disease, look to the Center for Disease Control website: www.cdc.gov.

Julie Kardos, MD and Naline Lai, MD

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*link corrected 4/18/2016

Digging out splinters



It's a sure sign of spring. Recently a mom showed me a splinter in her child's finger (pictured above) from running about outside and falling on wood chips.

If a splinter is very tiny (too small to grab with tweezers,) seems near the skin surface, and does not cause much discomfort, simply soak the splinter in warm soapy water several times a day for a few days. Fifteen minutes, twice a

day for four days, works for most splinters. Our bodies in general dislike foreign invaders and try to evict them. Water will help draw out splinters by loosening up the skin holding the splinter. This method works well particularly for multiple hair-like splinters such as the ones obtained from sliding down an obstacle course rope. Oil-based salves such as butter will not help pull out splinters. However, an over-the-counter hydrocortisone cream will help calm irritation and a benzocaine-based cream (for kids over 2 years of age) will help with pain relief.

If the splinter is “grab-able”, gently wash the area with soap and water and pat dry. Don’t soak an area with a “grab-able” wooden splinter for too long because the wood will soften and break apart. Next, wash your own hands and clean a pair of tweezers with rubbing alcohol. Then, grab hold of the splinter and with the tweezers pull smoothly. Take care to avoid breaking the splinter before it comes out.

If the splinter breaks or if you cannot easily grab the end because it does not protrude from the skin, you can sterilize a sewing needle by first boiling it for one minute and then cleaning with rubbing alcohol. With the needle, pick away at the skin area directly above the splinter. Use a magnifying glass if you have to, make sure you have good lighting, and for those middle-age parents like us, grab those reading glasses. Be careful not to go too deep, you will cause bleeding which makes visualization impossible. Continue to separate the skin until you can gently nudge the splinter out with the needle or grab it with your tweezers.

Since any break in the skin is a potential source of infection, after you remove the splinter, wash the wound well with soap and water. Flush the area with running water to remove any dirt that remains in the wound. See our post on wound care for further details on how to prevent infection. If the splinter is particularly dirty or deep, make sure your child’s tetanus shot is up to date. Also, watch for signs of

infection over the next few days: redness, pain at the site, or thick discharge from the wound are all reasons to take your child to his doctor for evaluation.

Some splinters are just too difficult for parents to remove. If you are not comfortable removing it yourself or if your child can't stay still for the extraction procedure, head over to your child's doctor for removal.

Now you can add "surgeon" to your growing list of parental hats.

Julie Kardos, MD with Naline Lai, MD
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**Before the Zika virus: A look
back at Rubella and
microcephaly**



photo credit: Laikipia Pixabay.com

The Zika virus in the news these days reminds us of another microcephaly-causing virus which scourged our world in the not-so-distant past. In the years right before the Two Peds doctors were born (late 1960s), the virus Rubella routinely swept through the United States and the rest of the world. The airborne germ Rubella, just like the mosquito-spread Zika virus, caused most people just a mild illness that they usually never even knew that they had. After they were sick, they became immune to the virus. But when pregnant women contracted Rubella early in pregnancy, their unborn children sometimes ended up with microcephaly.

Microcephaly is a condition where a small, underdeveloped, or abnormal brain leads to a small head at birth. Many children with microcephaly have significant mental disabilities.

So what happened to Rubella? It's the R in the MMR vaccine. We give this vaccine to all children, first at 12-15 months, and again at 4-6 years of age. We vaccinate girls to protect their unborn fetuses when they are pregnant, and we also vaccinate boys. Although boys will not become pregnant, they can contract the disease and spread it to others who are pregnant. It is standard practice for obstetricians to test all of their pregnant patients for immunity to Rubella. If a woman is not immune, she is given the MMR vaccine after delivery to prevent coming down with Rubella during future pregnancies.

Because of the success of this safe vaccine, it is extremely rare to have child born with Congenital Rubella Syndrome and its accompanying problems. The syndrome not only included the mental impairments associated with microcephaly but also was associated with blood disorders, heart defects, deafness, visual impairment, developmental delay, and seizures. In the United States where the vaccine rates are high enough, no cases have been reported since 2004. In the rest of the world, cases still occur in countries with limited access to vaccines against Rubella. Approximately 100,000 cases of Rubella worldwide per year still occur according to the Centers for Disease Control.

Scientists are working on a vaccine against the Zika virus because, as is often the case, preventing a disease is often easier, less costly, and more successful than attempting to cure it. For a basic explanation of how vaccines work, please see our prior post on this topic. Trials for a vaccine for Zika may begin as early as summer 2017.

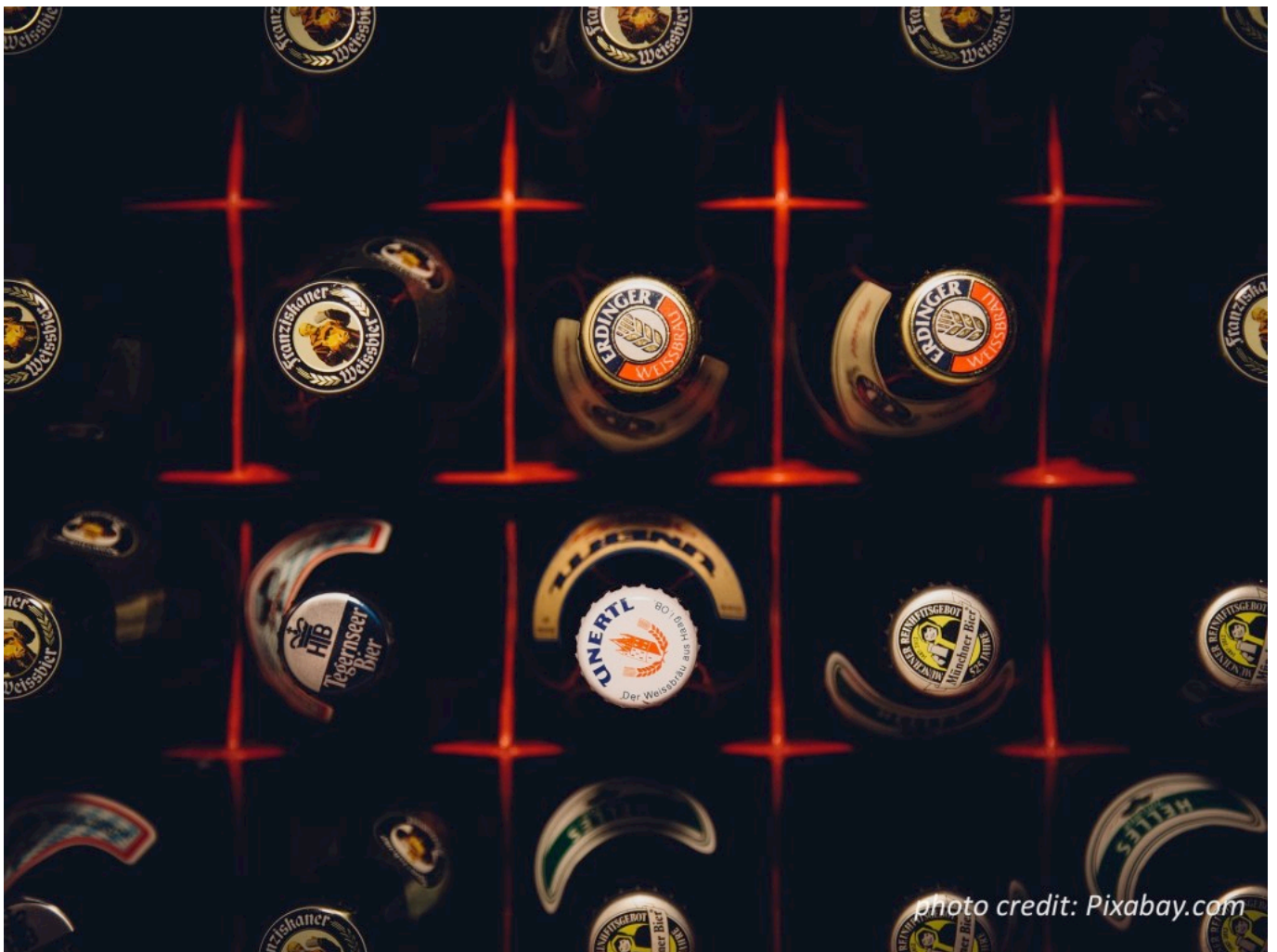
But if we look at history, Rubella was once a dreaded virus too. Now, with the widespread use of a vaccine, although still dreaded, the rates of Rubella have dropped dramatically. Zika

hopefully will not be far behind.

Naline Lai, MD and Julie Kardos, MD

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Binge drinking and college students update: what parents need to know



As your kids apply to college or return home from college for winter break, we urge you to keep in mind an alarming, yet

typical scenario which involves binge drinking that student health physicians encounter on a too-frequent basis—Drs. Kardos and Lai.

A 19 year old young man comes in to the Student Health Center very concerned because he had woken up that morning in an apartment in bed with a woman he did not know. He had been out with friends drinking at a bar (a frequent occurrence), vaguely recalls meeting a woman, but had so much to drink that he cannot even recall leaving the bar, let alone what happened afterward. His greatest concern is that he has no idea if he used a condom (he left before she woke up), and thus could have been exposed to HIV and other sexually transmitted infections.

Ironically, this student is worried about exposure to sexually transmitted diseases but not about the root of his problem: binge drinking. In other words, he is worried about sexually transmitted diseases but not about his drinking which caused his potential exposure to dangerous diseases.

Here is what Dr. David Turnoff, a career student health doctor since 2000 (and friend of Dr. Kardos) wants parents of college students to know about binge drinking in college students:

Although alcohol use is often considered a rite of passage for college students, it is also one of the major health risks for this age group. Alcohol-related health problems can present in a variety of ways and do not have to involve any signs of dependency. Among college-aged students, the most common manifestation of alcohol abuse comes from the consequences of binge drinking.

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) reports the following **sobering** statistics regarding health risks directly attributed to alcohol use among college students between the ages of 18 and 24. These statistics* also serve as an important reminder that a person does not have to

be drinking to be adversely affected by alcohol abuse.

-1,825 college student deaths from alcohol-related unintentional injuries (including motor vehicle accidents)

-599,000 unintentional student injuries

-696,000 cases of student-on-student assault

-7,000 cases of sexual assault or date rape

-400,000 students having unprotected sex and more than 100,000 students too intoxicated to remember if sex was consensual.

The first 6 weeks of the first semester of college is an important predictor of first year academic performance and is an important window period to monitor for any significant changes in a new student's behavior and lifestyle habits. Parents can help by being aware of these issues and by being open to speaking with their children about the potential risks of alcohol use both before and during the college experience. A simple rule of thumb for parents is to **stay involved**, while still allowing their children the space necessary for learning, exploring, and maturing into adulthood.

If your child begins to exhibit unusual behavior, such as lower grades, mood changes, or a new unwillingness to talk to you, this behavior should prompt you to find out more.

Additional information is available at <http://www.collegedrinkingprevention.gov/>.

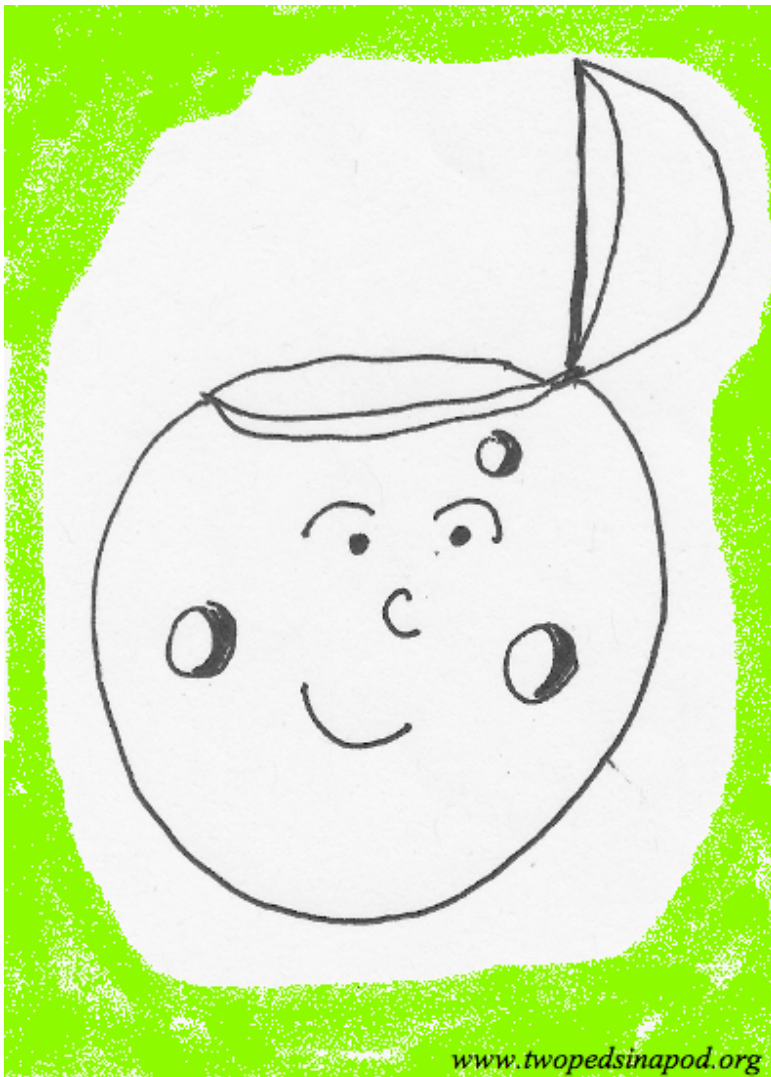
David Turnoff, MD

Dr. Turnoff is currently a college health physician at the University of California, Berkeley. In the past, he has served as a physician for New York University and Columbia. He received his medical degree at Case Western Reserve University.

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*worse since Dr. Dave's original post in 2010

Sinus infection or a cold?



Holes in your head – sinus infections

You have a hole in your head.

Actually, you have several.

You, your children, and everyone else.

These dratted air pockets in your skull can fill with pus and cause sinus infections. Scientists hypothesize they once helped us equilibrate in water while swimming. Now, sinuses seem only to cause headaches.

Sinuses are wedged in your cheek bones (maxillary sinuses), behind your nose (ethmoid sinuses) and in the bones over your forehead (frontal sinuses). When your child has a cold or allergies, fluid can build up in the sinuses. Normally, the sinuses drain into the back of your nose. If your child's sinuses don't drain because of unlucky anatomy, the sludge from her cold may become superinfected with bacteria and becomes too thick to move. Subsequently, pressure builds up in her sinuses and causes pain. A sinus infection of the frontal sinuses manifests itself as pressure over the forehead. The pain is exacerbated when she bends her head forward because the fluid sloshes around in the sinuses. Since frontal sinuses do not fully develop until around ten years old, young children escape frontal sinus infections.

Another sign of infection is the increased urge to brush the top row of teeth because the roots of the teeth protrude near the maxillary sinuses. Kids with sinusitis sometimes complain that their teeth hurt. Bad breath caused by bacterial infested post nasal drip can also be a sign. Occasionally kids with sinus infections develop swelling above or below the eyes, giving a puffy look to their faces.

The nasal discharge associated with bacterial sinus infections can be green/yellow and goey. However, nasal drainage from a cold virus is often green/yellow and goey as well. If your child has green boogies on the third or fourth day of a cold, does not have a fever, and is comfortable, have patience. The color should revert to clear. However, if the cold continues past ten days, studies have shown that a large percentage of the nasal secretions have developed into a bacterial sinus infection. To further confuse things for parents: a child can have a really yucky thick green/yellow runny nose and have "just a cold" or they can have clear secretions and have a sinus infection. In this case, the duration of symptoms is a clue to whether your child's runny

nose is from a cold or from a sinus infection.

Because toddlers in group childcare often have back-to-back colds, it may seem as if he constantly has a bacterial sinus infection. However, if there is a break in symptoms, even for one day, it is a sign that a cold has ended, and the new runny nose represents a new cold virus. Pediatric trivia: the average young child gets 8-10 colds per year, and colds last up to 10-14 days, sometimes even as long as three weeks. However, a cold seems better after 10 days even if some cough or mild nasal congestion lingers. Sinusitis is the cold that seems WORSE after ten days.

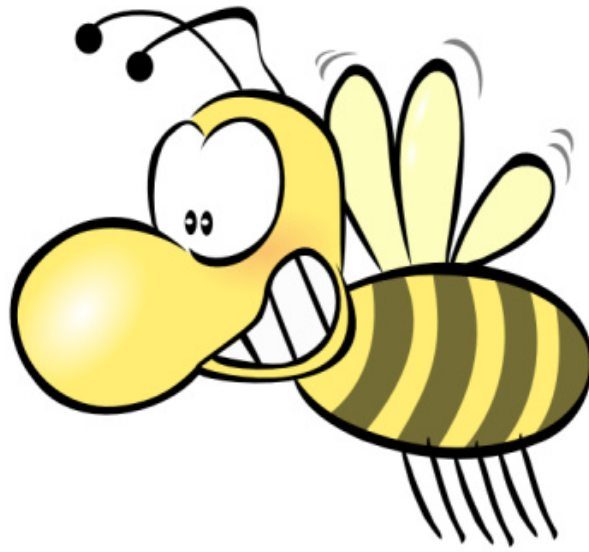
Hydrate your child well when she has a sinus infection. Your child's body will use the liquid to dilute some of the goo and the thinner goo will be easier for her body to drain. Since sinus infections are caused by bacteria, your pediatrician may recommend an antibiotic. The usual duration of the medicine is ten days, but for chronic sinus infections, two to four weeks may be necessary. Misnamed, "sinus washes" do not penetrate deep into the sinuses; however, they can give relief by mobilizing nasal secretions. When using a wash, ask the pharmacist for one with a low flow. Although the over the counter cold and sinus medicines claim to offer relief, they may have more side effects than good effects. Avoid using them in young children and infants. One safe and reliable way to soothe the nasal stuffiness of a sinus infection is to use simple saline nasal spray as often as needed.

Who knows. Someday we'll discover a purpose to having gooey pockets in our skulls. In the meantime, you can tease your children about the holes in their heads.

Naline Lai, MD and Julie Kardos, MD

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Ouch! Bee and wasp stings



(photo courtesy of WPCLipart.com)

Ouch! Stung on the scalp.

Ouch! Stung on the hand.

Ouch! Stung on the leg.

Ouch! Ouch! Stung TWICE on the lips.

Those nasty, nasty wasps. During the hot days of August, they become more and more territorial and attack anything near their nests. Today, in my yard, wasps mercilessly chased and attacked a fourth grader named Dan.

As everyone knows, you'd rather have something happen to yourself than have something negative happen to a child who is under your watch. As I had rolled out the Slip and Slide, I was relieved not to see any wasps hovering above nests buried in the lawn. I was also falsely reassured by the fact that our lawn had been recently mowed. I reasoned that anything lurking would have already attacked a lawn mower. Unfortunately, I failed to see the basketball sized grey wasp nest dangling

insidiously above our heads in a tree. So, when a wayward ball shook the tree, the wasps found Dan.

What will you do in the same situation?

Assess the airway– signs of impending airway compromise include hoarseness, wheezing (whistle like sounds on inhalation or expiration), difficulty swallowing, and inability to talk. Ask if the child feels swelling, itchiness or burning (like hot peppers) in his or her mouth/throat. Watch for labored breathing. If you see the child's ribs jut out with each breath, the child is struggling to pull air into his/her body. If you have Epinephrine (Epi-Pen or Auvi-Q) inject immediately- if you have to, you can inject through clothing. Call 911 immediately.

Calm the panic– being chased by a wasp is frightening and the child is more agitated over the disruption to his/her sense of security than over the pain of the sting. Use pain control /self calming techniques such as having the child breath slowly in through the nose and out through the mouth. Distract the child by having them “squeeze out” the pain out by squeezing your hand.

If the child was stung by a honey bee, if seen, scrape the stinger out with your fingernail or a credit card. Removal of the stinger prevents any venom left in the stinger from entering the site. Some feel scraping, rather than squeezing or pulling a stinger with tweezers lessen the amount of poison excreted. However, one study suggests otherwise. Wasps do not leave their stingers behind. Hence the reason they can sting multiple times. (Confused about the difference between wasps, hornets and yellow jackets? Wasps are members of the family Vespidae, which includes yellow jackets, hornets and paper wasps.) Relieve pain by administering Ibuprofen (trade names Motrin or Advil) or Acetaminophen (trade name Tylenol).

As you would with any break in the skin, to **prevent infection**,

wash the affected areas with mild soap and water.

Decrease the swelling and itch. Histamine produces redness, swelling and itch. Counter any histamine release with an oral antihistamine such as Diphenhydramine (trade name Benadryl). Any antihistamine will be helpful, but generally the older ones like Diphenhydramine tend to work the best in these instances. Just be aware that sleepiness is a common side effect.

To decrease overall swelling elevate the affected area.

Soothe the area by spreading on calamine lotion or by applying a topical steroid like hydrocortisone 1%.

And don't forget, ice, ice and more ice. Fifteen minutes of indirect ice (wrap in a towel, for example) on and fifteen minutes off helps relieve both pain and itching.

Even if the child's airway is okay, if the child is particularly swollen, or has numerous bites, a pediatrician may elect to add oral steroids to a child's treatment

It is almost midnight as I write this blog post. Now that I know all of my kids are safely tucked in their beds, and I know that Dan is fine, I turn my mind to one final matter: Wasps beware – I know that at night you return to your nest. My husband is going outside now with a can of insecticide. Never, never mess with the mother bear...at least on my watch.

Naline Lai, MD with Julie Kardos, MD

2015, updated from 2009, Two Peds in a Pod®

Marijuana: Hashing out Fact from Fiction

With some states now legalizing pot for recreational use, drug education for kids has never been more critical. The American Academy of Pediatrics released a policy statement this past year opposing legalization because of its potential harm to children, teens, and young adults. We welcome Dr. Shannon Murphy who dispels myths surrounding marijuana. – Drs. Kardos and Lai



Why is pot so different today than 30 years ago? Pot is 5 times stronger than the 1980's.

THC, the psychoactive ingredient in the plant, previously hovered around 3%. Now the average THC level is closer to 16%. As of this year, some plants have been tested with levels reaching between 20-30% THC. There is a new form of pot known as hash oil that is almost pure THC with levels around 90%

I heard pot was not addictive. Is that true? Pot is addictive.

In fact, the younger you are when you start using pot, the more likely you are to get addicted. 10% of adults and 17% of young adults who try pot will become addicted to it. If one chooses to use on a daily or near daily basis, the addiction rate climbs to 25-50%.

How long does pot stay in your body? Pot is different from

many other drugs because it can stay in your body for days after use.

In addition, the more you use pot, the longer it stays in your body. For regular users, it can remain in your body for several weeks. As a result, there is a sub acute impairment that persists with many users once the initial "high" has worn off.

When used, pot is distributed throughout one's body. These areas include the brain and spinal cord, heart, lungs, muscles, and fatty tissues. In fact, it is stored in fatty tissue. If one is pregnant and one uses pot, not only will the mom be affected by pot, but so will her unborn child. It also concentrates in breast milk. People who use marijuana should **NOT** breastfeed their baby.

Isn't pot safe to use? I heard it was safer than other drugs.
Pot is harmful to the brain, heart, and lungs.

Regular use of marijuana, particularly at a young age, can create biochemical and structural changes to the brain. Some of these changes are not reversible. Moreover, the effects are dose dependent. The more you use, the more likely to affect change.

Marijuana causes cognitive impairment. It harms learning, memory, attention, and critical decision-making. A recent study showed that regular use of marijuana at a young age causes a **permanent** decrease in IQ of up to 8 points.

Marijuana is linked to the development of mental health issues including anxiety, depression, and psychosis. Research has shown that regular daily to weekend use of pot increased one's risk of psychosis 3-5 times that of the general population. Sadly, we are seeing this played out in states like Colorado where people have died from psychosis related events.

The American Lung Association has reported that pot has more

cancer causing agents than tobacco smoke. Like tobacco, it causes chronic cough, wheeze, phlegm production, and frequent infections.

Marijuana has cardiac effects as well. Temporal links have been found between using pot and arrhythmias, stroke, and other major cardiac events.

What are “edibles”?

In 2014, with the legalization of pot in Colorado, the marijuana industry began selling food products with infused THC. These products, which include candy, cereal, pop tarts, and sodas, are indistinguishable from regular food.

In fact, exposure of kids to marijuana increased by 200% over this last year because of these products. These accidental poisonings were secondary to exposure of kids to edibles typically in their home. Many kids ended up in the ER, some with serious complications like seizures and difficulty breathing.

What does “dabbing” mean?

Dabbing is inhaling vapors from heating a concentrated form of pot. Dabs, which are also known as BHO (butane hash oil), “budder”, “honeycomb”, or “earwax” contain much higher concentrates of THC, usually upwards of 90%. Dabs are much stronger than a single joint and the high is administered all at once.

How does smoking pot affect driving?

Driving high is dangerous to the driver, others in the vehicle, and people sharing the road. In fact, marijuana is the number one illicit drug found in the blood stream of drivers involved in fatal car accidents.

Pot impairs skills needed to drive safely. It negatively impacts alertness, coordination, and reaction time.

Pot and alcohol don't mix. Using both drugs at the same time has been shown to increase the THC level in one's blood stream. This makes for a deadly combination on the road.

Is it okay to use pot while pregnant?

It is **NOT** okay to use pot while pregnant. As mom gets high and feels the effects of the drug, so does the unborn child.

Studies have shown that children exposed to marijuana in utero have lower scores on visual and motor coordination as well as lower scores on visual analysis and problem solving. In utero exposure is also associated with decreased attention span and behavioral problems. Finally, studies have shown that teens are more likely to be marijuana users if their mom used while pregnant.

What if my teen says that since pot isn't a big deal anymore and many of their friends are using it?

Now more than ever, it is incredibly important to speak clearly regarding the risks of pot use. Many teens see legal as meaning safe, so we are entering a critical time when it comes to our kids and marijuana use. Here are a few suggestions when it comes to talking to your kids about drug use in general.

Talk early and often. This should not be a one-time conversation.

Make sure your child knows your rules on drug use and set clear consequences if these rules are broken. Role-play real life situations so kids can know how to respond when confronted with scenarios that may involve drugs. Base education about pot and other drugs on facts.

Check out the National Institute of Drug Abuse website for up to date information. To learn more visit www.learnaboutsam.org

Shannon Murphy, MD, FAAP

Dr. Murphy is a board certified general pediatrician who currently serves on the American Academy of Pediatrics Practice Advisory Committee for Adolescent Substance Use. She heads a non-profit coalition, SAM Alabama, whose goal is to educate parents and kids on the public health issues and safety concerns associated with marijuana.

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The natural medicine cabinet in your kitchen



photo by Lexi Logan www.lexilogan.com

You may not think of your kitchen as a convenient pharmacy, but parents used common kitchen items successfully to treat various maladies long before CVS and Walgreens were invented.

Crisco– May not be healthy to eat, but smeared on skin, it's an old fashioned but effective treatment for eczema or [dry skin](#).

Oatmeal– Crush and put into the end of a hosiery sock. Float the sock in the bathtub for a natural way to moisturize skin.

Olive Oil–

- Put a couple drops into the ear three times a day to loosen ear wax (don't put in if your child has a hole in their ear drum eg. myringotomy tubes).
- For cradle cap, rub into your baby's scalp and use your fingernail or a soft brush to loosen the greasy flakes.
- Also use to kill [lice](#). Work the oil through the scalp, tuck hair into a shower cap and wash off in the morning. Although studies are unclear on how well this method works on lice, it certainly is worth a try.

White vinegar-If [swimmer's ear](#) is suspected, mix rubbing alcohol one to one with vinegar and drop a couple drops in the ear to stop the swimmer's ear from progressing (don't put in if your child has a hole in their ear drum eg. myringotomy tubes).

Ginger– Boil ginger to make a tea to take the edge off nausea

Honey– Shown to soothe coughs-give a teaspoon of dark (buckwheat, for example) honey three times a day. However, NEVER give honey to a child who is younger than one year of age because it may cause infant botulism

Lemon– An old singer's trick–combine lemon juice with honey in tea to alleviate hoarseness

Salt– Mixed into lukewarm water, gargling with salt water will

help ease sore throat pain

Baking soda:

- Mix with water to make a paste to help soothe itchy skin, from maladies such as [poison ivy](#).
- Can also be mixed with water to make toothpaste if you run out of your usual minty whitener.
- Another use of baking soda: one part baking soda with 4 parts corn starch makes a natural underarm deodorant.

Sugar: Mix sugar into weak tea (or your ginger tea from above) and give small amounts frequently to soothe your **older** child's nausea and help rehydrate after vomiting.

Ice: Ice not only decreases swelling when applied to injuries, it can also be used to combat the itch of bug bites and poison ivy.

Kitchen sink: This is an excellent place to wash any [cut, scrape, or bleeding wound](#) under running water with soap. Immediately after a burn, rinse the burned skin under cold water for several minutes to limit the extent of the heat injury. Contrary to popular lore, DO NOT put butter on a burn. You may, however, put butter on your toast. In small amounts.

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The surprising first signs of dehydration



It's 100 degrees Fahrenheit outside. We're hiking around the Southern Utah desert and one of my kids vomits once. Nope,

it's not the stomach bug; that was last vacation. This time one of my kids vomited because of dehydration. Strangely, humans don't always complain of thirst once they start becoming parched, and my kid was no exception.

Right now many kids are at camp running about in high temperatures and soon enough, kids will be called back to school for sport practices. Before they go off, let them know that the first signs of dehydration are usually a vague headache and nausea. Warn them not to depend solely on their sense of thirst to signal them to hydrate. If they "just don't feel right," take a break. Other signs of heat exhaustion and stroke are outlined here <http://www.cdc.gov/extremeheat/warning.html>

For kids who play only for an hour or so, water is a good choice for hydration. For the more competitive players who churn up a sweat or participate in vigorous activity, electrolyte replenishers such as Gatorade® and Powerade® become important, because after 20-30 minutes of sweating, a body can lose salt and sugar as well as water. In fact, my sister, an Emergency Medicine doctor, tells the story of a young woman who played ultimate frisbee all day, and lost a large amount of salt through sweating. Because she also drank large amounts of water, she "diluted" the salt that was still in her blood and had a seizure.

If your child plays an early morning sport, start the hydration process the night before so that they don't wake up already behind on fluids. If your child goes more than six to eight hours without urinating, she needs to drink more.

Avoid caffeine which is found in some sodas, iced tea and many of the energy drinks. Caffeine dehydrates. The American Academy of Pediatrics recommends that children and teens never drink "energy drinks" because of the adverse effects of the stimulants they all contain. Some of the newer highly touted rehydration fluids of the adult world such as coconut water or

chocolate milk are fine.

Keep in mind it's not only sports that can dehydrate kids. Years ago I knew of a tuba player who went to the emergency room after marching band practice on a hot August day.

Next vacation we'll definitely buy some water bottles to make sure we don't get dehydrated. Not having enough water can be so dangerous! We'll also take along paper towels and cleaning fluid too.

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Soothe the itch of poison ivy



Recently we've had a parade of itchy children troop through our office. The culprit: poison ivy.

Myth buster: Fortunately, **poison ivy is NOT contagious**. You can catch poison ivy **ONLY** from the plant, not from another person.

Also, **contrary to popular belief, you can not spread poison**

ivy on yourself through scratching. However, where the poison (oil) has touched your skin, your skin can show a delayed reaction- sometimes up to two weeks later. Different areas of skin can react at different times, thus giving the illusion of a spreading rash.

Some home remedies for the itch :

- **Hopping into the shower and rinsing off within fifteen minutes** of exposure can curtail the reaction. Warning, a bath immediately after exposure may cause the oils to simply swirl around the bathtub and touch new places on your child.
- **Hydrocortisone 1%.** This is a mild topical steroid which decreases inflammation. We suggest the ointment- more staying power and unlike the cream will not sting on open areas, use up to four times a day
- **Calamine lotion – a.k.a. the pink stuff.** This is an active ingredient in many of the combination creams. Apply as many times as you like.
- **Diphenhydramine (brand name Benadryl)- take orally** up to every six hours. If this makes your child too sleepy, once a day Cetirizine (brand name Zyrtec) also has very good anti itch properties.
- **Oatmeal baths –** Crush oatmeal, place in old hosiery, tie it off and float in the bathtub- this will prevent oat meal from clogging up your bath tub. Alternatively buy the commercial ones (e.g. Aveeno)
- **Do not use alcohol or bleach–** these items will irritate the rash more than help

The biggest worry with poison ivy rashes is not the itch, but the chance of infection. With each scratch, your child is possibly introducing infection into an open wound. Unfortunately, it is sometimes difficult to tell the difference between an allergic reaction to poison ivy and an infection. Both are red, both can be warm, both can be swollen. However, **infections cause pain** – if there is pain

associated with a poison ivy rash, think infection. **Allergic reactions cause itchiness**– if there is itchiness associated with a rash, think allergic reaction. Because it usually takes time for an infection to “settle in,” an infection will not occur immediately after an exposure. Infection usually occurs on the 2nd or 3rd days. If you have any concerns take your child to her doctor.

Generally, any poison ivy rash which is in the area of the eye or genitals (difficult to apply topical remedies), appears infected, or is just plain making your child miserable needs medical attention.

When all else fails, comfort yourself with this statistic: up to 85% of people are allergic to poison ivy. If misery loves company, your child certainly has company.

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